State of Vermont
Assistive Technology Program
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Agency of Human Services

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Authorization to Obtain or Release Information updated 5/14/12

I, (print name) _____ , give permission for any information in _____'s file relevant these items:
_____

—— to be ___exchanged with ___released to, or
___obtained from:
The Vermont Assistive Technology Program (VATP) at the
following address:
The information is needed to:
□ Coordinate services □ Other (specify) _____
This permission is granted to the agency or individual listed below:
Agency/Individual Name _____
Phone Number _____
Address_____

Note: A separate release is required for each agency/individual contacted for release of information.

The VATP may request records in certain circumstances to assist us in better serving you. I understand that my records are protected under HIPPA and FERPA (in some cases), as well as federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42CFR Part 2) and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.
I give specific permission to release information re: treatment for: (Please place your initials on the applicable lines) _____ Alcohol abuse _____Drug abuse _____AIDS/related diagnosis.
Special instructions: _____
This consent will expire three years from the date signed unless an earlier date is listed here:
_____ . I understand that I may cancel my consent at any time by submitting a written request to the Vermont Assistive Technology Program and that any cancellation will not affect information already released.
Signature of Consumer_____Date of Birth_____Date Signed_____

Signature of Parent / Guardian_____Date Signed_____

VATP representative_____Position/Job Title_____Signature_____Date Signed_____